EDITORIALS

Elective Operations and the Death Rate

AT A RECENT MEETING of the American Public Health Association Dr. Milton L. Roemer reportedly noted that there was a significant drop in the death rate in Los Angeles County in early 1976 when many doctors withheld their services to protest rising malpractice insurance premiums. Dr. Roemer is said to have attributed the lower death rate to the sharply reduced amount of elective surgical procedures that occurred during the slowdown. The *Washington Post* then reportedly quoted Dr. Roemer as saying that the lower death rate lends support to "the mounting evidence that people might benefit if less elective surgery were performed in the United States" and that greater restraint in carrying out elective surgical operations might well improve life expectancy. All of this has received considerable publicity.

It is not the intention here to question the data and it is even possible that the interpretation attributed to Dr. Roemer may be correct. But if so, the interpretation (1) assumes that the operations postponed and therefore not done during this period were elective in the sense that they might not need to be done at all and (2) implies that elective operations on the whole do more harm than good. For the first it seems obvious that many necessary, serious and even risky operations or procedures can safely be postponed until conditions are optimal to undertake them. This is often done and seems more than likely to have occurred in many instances during the trying period early in 1976 in Los Angeles when many would have considered conditions for nonemergency operations less than optimal. For the second it would seem reasonable to consider the benefits for which the risks were or would have been taken had these "elective" operations been done. This point does not seem to have been addressed. But again, it seems likely that in many and possibly most of these instances, there would have been benefits which in the opinion of the doctor with the informed consent of the patient would have been worth the risk of operation to the patient. Coronary bypass and inguinal herniorrhaphy are two surgical procedures which are ordinarily not considered emergencies but neither are they in the same elective category as rhinoplasty for cosmetic purposes, for example. But even in this instance it may be well worth it to the patient. Certainly in the appropriate instances and at the appropriate times it is good medical practice to do these operations and to assume the risks to achieve the benefits for the patients.

It is becoming evident that the costs, risks and benefits of various physician interventions in patient care will be undergoing increasing study and scrutiny. It is most important that when this is done, these risks, benefits and costs be accurately assessed in relationship to one another as each physician intervention is studied.

—MSMW

Physical Child Abuse

THE CURRENT ISSUE of this journal carries a report from the Sacramento Medical Center on the initial findings and short-term outcome of cases of physical child abuse, diagnosed and reported during the calendar year 1975. This is welcome feedback to the medical profession on some of the reports initiated by physicians, a feedback lacking in most communities. During the past 15 years the problem of child abuse has been highlighted both in lay and professional literature. All 50 states have enacted laws requiring physicians and many other professionals to report suspected child abuse. Vice President Mondale, while he was still in the Senate, was instrumental in establishing a National Center for Child Abuse and Neglect responsible for conducting educational and demonstration research programs in the field of child abuse. Each federal district has a regional child abuse project and the state of California now has an Office of Child Abuse Prevention. These are all positive steps and one would expect them to improve the quality of life for abused children and their families, and to avert some abuse in the future. Prevention of child abuse before it occurs is an even more important goal of these programs. However, the true extent to which such improvement has oc-

curred is not at all clear, and still remains to be documented. In the meantime the current mood of many state legislatures is to stress reporting and impose increased penalties for failure to report child abuse. Among the recently enacted statutes is one requiring that all medical students receive instruction in child abuse before they can be granted an MD degree; one requiring mandatory continued instruction in the field of child abuse for physicians as a condition for relicensing, and one which would significantly increase penalties for failure to report abuse. Many other proposed bills would change various aspects of reporting and registries for child abuse cases. In addition, new written forms for reporting have been prepared recently by the state Attorney General and compliance with the new forms will probably be requested in the near future.

We heartily endorse the current reporting laws as a *beginning step* in protecting children at risk and assisting family units in handling crisis situations. No doubt the present laws could be improved, particularly by clarifying the statute, but the important fact is that reporting child abuse for the sake of compiling statistics has no redeeming value.

Physicians are motivated to report child abuse in order to protect the patient from further harm, to be law abiding and because of their awareness that failure to report may carry some civil liability if the child should come to further harm.

On the other hand the medical community should insist that such a report lead to prompt intervention designed to protect the child. This is a challenging task but the framework for successful intervention has been nicely delineated.[1] Removing a child from a family to long-term, sometimes open-ended foster care is not in the best interest of the family or the child; and is very expensive for society. The diagnosis of child abuse should result in prompt, humane intervention, perhaps a short period of separation, and organized coordinated support for families permitting the safe return of the child into the home. An alternative for a minority of instances is termination of parental rights leading to early adoption or legal guardianship when it is clear that family reunification cannot be achieved. The California Legislature has recently authorized a four-year trial of an innovative plan of this type in three counties in the state. We would like to emphasize that there is ample evidence that the child, as well as the family, needs special support and treatment.[2] Physicians, who so often initiate the child abuse report, need to join with other professionals and parent groups, participate in community child abuse councils and work towards the realization of these goals.

The present retrenchment of local tax revenues makes it particularly timely and urgent that we emphasize these expectations and that we continue to receive feedback on the events that follow the reporting of child abuse cases. Yes, we as medical professionals assume the obligation for reporting child abuse and will be accountable for failing to do so. It is only fair that we should expect the agencies that receive our reports to be equally accountable for the actions and outcomes that follow. Such outcome studies and reports are essential in order to judge the effectiveness of the statutes, programs and fund expenditures. We hope to see more of them in the future on the pages of this and other journals.

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2. Martin HP: The Abused Child, Cambridge, Ballinger Publishing Co, 1976

On Assuring Health Through Health Care

ON THE FACE OF IT, it sounds logical enough to assure health for all by making health care available to all and persuading everyone to take advantage of it. This has been a widely accepted thesis for some years and it has been one upon which much health planning and many costly initiatives of government have been based. Now it appears that as more health care becomes available to more people who use more if it, health does not improve proportionately to the effort and dollars expended. It would seem that there must be some kind of fallacy in this thesis or assumption which has seemed so logical to so many.

It is suggested that an explanation may lie in the almost casual substitution of the word-symbol "health" for the word-symbols that mean illness, injury or sickness of whatever kind. It appears to have started when medical insurance was designated health insurance, and when medical care